



Cost Containment Meeting Summaries

Sterling and Greeley

July 20, 2016

Background

The Colorado Commission on Affordable Health Care's (Commission) mission is to ensure that Coloradans have access to affordable health care in Colorado. It is charged with making recommendations to the General Assembly focused on evidence-based cost control measures, access to care, and quality health care improvement initiatives, as well as the cost effective expenditure of limited state moneys to improve the health of Colorado's population.

Stakeholder engagement is critical to the work of the Commission. Buy-in from stakeholders will be essential for the Commission's long-term success and its ability to meet its legislatively mandated goals. To that end, all Commission meetings are open to the public and broadcast via ReadyTalk, and public comments are always welcome on the Commission's website. The Commission has also distributed a questionnaire to key health care stakeholders to gather statewide feedback on multiple topics.

In 2016, the Commission will hold nine statewide meetings to solicit additional stakeholder feedback on its work and recommendations so far. These meetings will not only provide vital input to the Commission's work and recommendations to date, but also build support for and community ownership of its eventual recommendations. This summary focuses on the Sterling and Greeley meetings held on July 20. The Commission also held meetings Colorado Springs, Alamosa, Grand Junction, Summit County, and Adams County earlier this summer.

Commission Presentation

Both meetings began with a presentation of the Commission's work to date. Commissioners explained the origin of the Commission and its charge, the makeup of the Commission, and the goals for the stakeholder meetings, emphasizing the importance of public feedback and input throughout the life of the Commission. Attendees were given a chance to ask questions about the presentation before opening up to a broader dialogue organized around the following key questions:

- What do you think are the fundamental cost drivers in your region and why?
- What are the barriers to reducing cost?
- What would you change to make things better related to cost?
- Do you have any thoughts on the recommendations and topics that the Commission is addressing?

In both meetings, the Commissioners emphasized that they have learned that there is no one driver or entity causing all of the problems and driving up cost single-handedly; rather, multiple factors have contributed to the rise of health care costs in Colorado. The Commission encouraged attendees to consider challenges and recommendations across a range of topics.

Summary of Stakeholder Feedback: Sterling

In Sterling, about 20 individuals attended the meeting; many worked in health care or represented local businesses, and a few were in attendance to represent the consumer perspective. Conversation focused on challenges and recommendations related to the following key themes:

- **Unique challenge for rural populations:** Many cited frustrations with the disparities between medical care and insurance offerings in rural Colorado versus the Front Range and wondered why there has to be such a discrepancy. The same tests in Sterling often cost four times more than the tests in Denver. This is also true for specialists.
- **Facilities:** The acuity level of patients is skyrocketing, but there is no critical access hospital (just a level three trauma center). Sterling patients are frequently subject to expensive hospital rides to Denver. On nights and weekends, residents have no choice but to go to an emergency rooms, where the costs are much higher for the same services.
- **Population challenges:** The Sterling attendees frequently brought up the challenges with a population where 30% are ages 20-39. Young people are attracted to Sterling (and the city wants to keep attracting them), but small businesses don't offer health care. There is a lack of employer-based coverage; the challenge seems to be the number of people in the individual market. Additionally, 28.4% of the payer population is Medicare.
- **Social determinants:** Sterling attendees cited concerns with social determinants, including increasing STD rates, poverty issues, and nutrition challenges, partly due, they thought, to growing ethnic diversity. They also talked about environmental challenges, especially high rates of asthma due to exposure to pesticides. It was acknowledged that addressing all social determinants wouldn't fix all of the county's health care problems, but it could help a great deal. One Commissioner wondered if the size of Sterling could be used to its advantage in order to offer better services, because that can be easier to do in smaller communities.
- **Workforce:** Attendees cited workforce challenges, including physicians working fewer hours and community resistance to seeing a PA or RN in place of a beloved and well-known family doctor. Additionally, mental health care practitioners are lacking (and there is little funding for mental health). Specialists are also lacking, and many require a visit to Denver. The hospital executive in attendance said that Sterling now has three full time surgeons, a full time radiation oncologist, a full time medical oncologist, and excellent technology for cancer treatment, but that it can be hard to balance the desire for full range services with the cost effectiveness of repetition. Some mentioned that direct primary care practices are becoming more and more popular, because the doctors are able to reduce all of the paperwork related to insurance, which can lead to an improvement in care for a reduced cost. But it can be bad for patients, because the doctors likely can't continue to serve the same number of patients that way.
- **Electronic Health Records:** Attendees felt frustrated that EHRs had hampered productivity.
- **Pharmaceuticals:** Many attendees cited pharmaceutical companies as the real negative force. One attendee expressed frustration that he could only get his prescriptions in the mail, all from different places. Others expressed frustration that pharmaceutical costs had indeed increased greatly over the last for years, pointing as examples to a tenfold increase in the cost of a certain brand of inhaler and the high cost of materials to test insulin for diabetics. One attendee was frustrated that her insurance required her to buy more expensive pharmaceutical products.
- **Consumer education:** Many discussed challenges with lack of education, especially with Medicaid. They pointed to the need for education on what merits an ER visit.
- **Competition/transparency:** In a place like Sterling, you might well know the options for health care, but the options are shrinking rapidly. There are limits to the number of options and

carriers, and no PPOs will be available starting next year; plus, the options available through Obamacare change every year. As carriers disappear, price increases. An attendee who worked for a hospital pointed out that Sterling (with 56,000 lives) has neither the competition nor the volume to drive costs down, which is a particular challenge since Denver is close enough to be an option for meeting health care needs. Many attendees felt strongly that they wanted as many options as possible, even if some of those options are incredibly expensive. They said they would pay more if it meant that they could see the specialists they wanted to see. All in all, they emphasized that choices and transparency in insurance and providers and transparency in hospital bills would be very helpful.

The Commissioners tried to steer the conversation toward some ideas for solutions to these health care challenges. They emphasized the importance of thinking about what can be tackled at the federal, state, and community level. With declining trust in public institutions, there may be more value in making changes at the local level.

- One attendee suggested having a base level of care that is essentially socialized medicine, and then charging for additional services. They emphasized the importance of figuring out what core access looks like, and then scaling up from there. Others cautioned that a system like that would lead to redrawing the borders of the town and trying to keep certain people out.
- One attendee mentioned that tort reform could make a difference. Doctors are so afraid of trying to get sued that they run more tests than they might need to rule out every possible cause of a health care issue, driving up costs.
- Attendees liked the idea of certain specialists from the Front Range being available once a week or a few times a month in a Sterling hospital. They also said they'd be interested in taking some appointments over the phone to help address the workforce challenges.

At the end of the discussion, attendees emphasized how nice it was that the Commission came out to Sterling; they very much appreciated that people were paying attention to and listening to the Eastern part of the state.

Summary of Stakeholder Feedback: Greeley

In Greeley, about 12 individuals attended, and most worked in the health care field. Conversation focused on the following key themes:

- **Facilities:** Attendees were frustrated by the overbuilding of hospitals, pointing to the increase in freestanding ERs and the disappearance of certificates of need: "The edifice complex of health care needs to be reconsidered." The two hospital systems in Greeley are trying to outcompete and out-build one another as the impoverished population remains neglected. As in other cities, Greeley attendees discussed the overuse of ERs; with more freestanding ERs going up, primary care is going downhill. But in addition to being more expensive, ERs don't offer the ongoing attention that primary care facilities do. And yet, by way of example, Medicaid patients will be denied MRI authorization in primary care and then simply drive down the street and get an MRI at the ER without pre-authorization. Attendees thought that even a small ER co-pay could help deter these kinds of patients. One said that freestanding ERs simply shouldn't exist; they must be affiliated with a hospital.
- **Transparency:** Attendees were frustrated with a lack of truth and transparency in billing. Many agreed that hospital masters are a fiction that does not tie back to actual costs, and costs vary widely among facilities. Attendees strongly suggested site-neutral payments. One suggested an easier-to-use state website for cost transparency and cost comparison, citing Vitals, Inc. in New England as a company offering great tools for cost transparency.

- **Pharmaceuticals:** One attendee called big pharma the merchant of life and death. One pointed to overprescribing of drugs, especially opioids.
- **Workforce:** Attendees talked about the importance of exposing the developing workforce to rural areas, improving patient-nurse ratios, and offering nurse shifts in-home under Medicare/Medicaid. One attendees said that doctors need more medical assistants to help with administrative burdens. Rates of physician burnout are increasing, in part because of burdens related to clerical tasks and electronic health records. One attendee said that labor needs for pharmaceutical techs, in particular, are off the charts.
- **Behavioral health:** Attendees emphasized the importance of parity, which has not been achieved despite legislation requiring it. One suggested offering acute treatment units for psychiatric care as an alternative to psychiatric hospitals (or as a step down from those hospitals). Attendees discussed the challenge of getting reimbursed for behavioral health treatment; Greeley can only reimburse because of capitated payments.
- **Social determinants:** As housing is improved in a neighborhood, health care costs drive down. Attendees emphasized the importance of considering these relationships and having interdisciplinary conversations around health care. Education, housing, poverty: these are all health care issues.
- **Cost drivers:** Attendees point to a number of specific areas where costs could be driven down:
 - End-of-life care. They also expressed frustration with the fact that there is no consistent and widely accessible place to house advanced care directives.
 - Fraud
 - Missed prevention opportunities (e.g., only 25% of the population is fluoridated, but for every \$1 invested in fluoridation, \$65 is saved in dental costs; the state has incredibly low vaccination rates)
 - Unnecessary services
 - One attendee talked about the high rates of back surgeries in Colorado and suggested some sort of state tool to help patients determine whether a more conservative treatment should be pursued
 - Reimbursement of “quack” medicine like lay midwives and homeopathic doctors
 - Medical devices (when hospitals purchase them, they sign a contract promising not to reveal the cost of the device to other hospitals or even their own physicians)
 - Cost overruns on surgical appointments (e.g., missing appointments, not doing appropriate home preparation)

When it comes to solutions, the group discussed Patient-Centered Medical Homes as a system for increasing value. PCMHs can offer better data and relief from administrative burdens in order to treat more patients. Attendees and Commissioners also discussed the value of team-based practices, which can better integrate behavioral health. One attendee emphasized the importance of care coordinators, using the example of a diabetic who was not taking his medicine. It took a care coordinator to figure out that he wasn’t filling his prescriptions because he couldn’t read and was too proud to admit it. One attendee suggested turning to the Boeing model as a solution: they set up their own network apart from the high deductible model.